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Contemporary Periodontics & Implant Dentistry
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727-579-8487 Fax 727-578-8500

DENTAL IMAGING REFERRAL FORM

REFERRING DENTIST INFORMATION

Full Name: ____ Date Referred: ___________________
Address: ____
Telephone: _____________________________ E-mail: ____________________________________

PATIENT INFORMATION

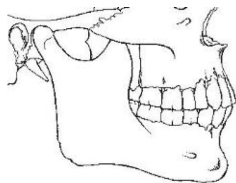
Patient's Name: ______________________________________ Date of Birth: ________________
Patient's Address: ____
Home Tel: _____________________________ Mobile Tel: _______________________________
(Check all that apply)

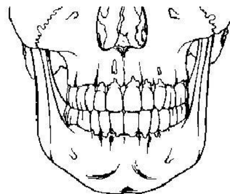
REASON FOR REFERRAL:
_____ TMJ Assessment _____ Sinus Assessment _____ Airway Assessment
_____ Endodontic Assessment _____ Implant Assessment _____ Implant Surgical Placement Only
_____ Implant Surgical Placement & Restoration _____ Implant Problems & Diagnosis
_____ Augmentation & Surgical Placement _____ Entire Maxillofacial Region _____ Orthodontic
_____ Oral Pathology _____ Impaction Other: ______________________________________

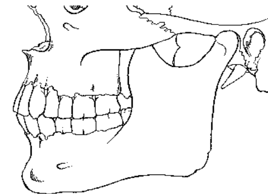
____**Cone Beam CT** ____**Digital Panoramic** ____ **Cephalometric**

Region(s) of Interest:
____
____

Circle Area:







FORMAT DATA DELIVERY OPTIONS FOR SCAN:

___ E-MAIL
___ PRINTS
___ DUPLICATE CD NEEDED
___ Other: ___________________________________

Please send by FAX to 727-578-8500 or
SCAN and EMAIL, RE: Patient Referrals to: Glangston@ContemporaryPerio.com
ONCE COMPLETED HAVE PATIENT CALL TO SCHEDULE AN APPOINTMENT